ADDITIONAL QUESTIONS FOR THE RECORD

Questions: The Honorable Joseph R. Pitts
Answers: Judy Feder

1. Under the Affordable Care Act/"Obamacare," states have the option to expand Medicaid to adults with no children with income under 138% of the federal poverty level. This was an unprecedented expansion of the program that traditionally have covered low-income moms and kids, the elderly poor, blind and the disabled. Under the expansion, the federal government is paying 100 % of cost of the expansion until 2016, when states have to start picking up some of the tab. Accordingly, under federal rules today, the federal government is paying:
    a. The full cost of some prisoners' hospital care who would otherwise be eligible for Medicaid
    b. The medical bills of multi-million dollar lottery winners whose states are barred from disenrolling on the program. Do you this think is an appropriate use of Medicaid dollars? Why or why not?

Judy Feder's Answer: Under the ACA, as before, Medicaid is a program that provides health and long-term care benefits to people who are poor or who become poor by virtue of their spending on care. What's new with the ACA is an end to the exclusion from coverage of low income adults, no matter how poor, who are neither disabled nor parents of dependent children. That exclusion left millions without health insurance protection—whether because they were not offered it through their jobs (most of them work or are in workers' families) or because they could not afford it on their own.

The ACA aims to close this gap—benefiting millions of Americans. Achieving that goal is, to me, far more significant than whether the program may cover some who've been covered elsewhere or a miniscule number of lottery winners.

2. What do you think Congress should do to assess the situation of disabled children on waiting lists to access home and community based services in Medicaid?

Judy Feder'sAnswer: Most states cover home and community-based services under federal waivers that allow states to limit the number of people served—in other words, waiving the requirement that Medicaid benefits be provided to all people who are eligible for the service. That limitation could be addressed if home care, like nursing home care, were a mandatory benefit. In practice, however, the limitations represent states' reluctance to expand spending, even to populations clearly in need of service. It's my view that more federal resources are required to adequately meet long-term care needs for children and others who need basic assistance with tasks of daily living.

3. I was glad to hear you mention state flexibility to manage Medicaid programs. Do you think states should have to negotiate or obtain permission from CMS to increase co-pays by $2 (as is happening under expansion)?

   Judy Feder's Answer: I mention flexibility because it exists under current law and policy—not because I think more flexibility is needed. Medicaid is designed to give states considerable flexibility in managing their programs, subject to federal rules intended to assure adequate and affordable benefits for all people eligible to participate. What may seem like a modest change in copayment on a single service may add up to a substantial financial burden—and barrier to access—for people with limited resources. Federal approval is necessary to assure that policy changes don't create such a barrier.

4. The bipartisan Rivlin-Domenici Debt Reduction Task Force – led by former Clinton White House OMB Director Alice Rivlin and Republican Senator Pete Domenici—noted that two of their foundational principles were to (a) protect the truly disadvantaged to ensure a sustainable safety net while (b) making spending reductions and adopting policy reforms that focused benefits on those who need them the most. In this vein, what policies would you recommend to Congress that would reduce Medicaid spending, while adhering to these sound principles?

   Judy Feder'sAnswer: Per capita Medicaid spending, like all health care spending, is currently growing at extraordinarily low rates. Growth in total Medicaid spending does not reflect inefficiency; rather it reflects increased numbers of beneficiaries—because of the recession pre-ACA and expanded eligibility post-ACA. Medicaid already pays less for services than other payers; and it is involved along with other payers in reforming payment and delivery mechanisms to promote better quality of care and better value for the dollar. Medicaid is already targeting its benefits to people who need them most. In short—I see no need to take additional actions to reduce Medicaid spending.

5. Many of the members from both sides of the aisle at the December 3rd hearing, as well as health care providers and children's advocates, have praised CHIP as a program that is currently successful. Would you agree with that general sentiment?

   Answer: I would agree.

6. CBO has said that the 23 percent increase to the E-FMAP in current law does not result in extending health coverage to any more children—it just effectively buys out the states. So, should Congress just scrap the E-FMAP in current law and use those savings to help extend CHIP funding?

   Answer: I am surprised that CBO concludes that a withdrawal of federal funds will have no impact on population coverage—that is, that they assume coverage will remain at current levels. To my knowledge, states take a very different point

of view and believe their ability to continue covering children under CHIP will be impeded by a cutback in federal funds. Further, opponents of the ACA are likely to characterize such a cutback as evidence of the "unreliability" of federal funding they claim as a reason for rejecting the expansion. Scrapping the E-FMAP could therefore have a political as well as a policy impact on states' support for children's coverage.

7. According to information released by the Actuary of the Centers for Medicare and Medicaid Services, drug spending is projected to hold steady for the foreseeable future at 10 to 15 percent of National Health Expenditures. However, the Actuary did note that the emergence of specialty drugs presents cost challenges for some payers. This is especially the case in Medicaid, where individuals receiving life-saving cures may churn in and out of the program based on their income. Unlike the defacto price control in the Medicaid program, the Medicare program has the benefit of a competitive program with varying formularies and plans, where a senior can pick a plan that meets his or her needs. So, have any of you thought about targeted policies to give plans and states more control over their drug spending?

   Answer: The problem of specialty drugs has nothing to do with competition ; it has to do with producer monopoly power in the production of a needed drug. Limited formularies don't help when only one company produces a needed drug. Addresing that problem requires greater government authority wherever it resides. Further, it is worth noting that the shift of responsibility for prescription drug coverage for dual eligibles from Medicaid to Medicare has actually significantly increased expenditures on prescription drugs. As you note, Medicaid has discounting authority that Medicare lacks.

8. CBO has estimated that repealing or delaying the IRS' authority to fine Americans for failing to buy government-approved coverage, otherwise known as the individual mandate, would result in tens of billions in savings for federal taxpayers. Taking away IRS' authority to punish Americans under Obamacare seems like a common sense proposal to limit government and save taxpayer dollars. One objection to this idea we often hear is than an individual mandate is necessary to cover pre-existing conditions. However, isn't it true that we can cover pre-existing conditions without an individual mandate while ensuring market stability through other mechanisms? (e.g. Medicare late enrollment penalties, high risk pools, continuous coverage underwriting protections, etc.).

   Answer: The mandate is not a punishment; it's a mechanism to assure that everybody contributes to health insurance, rather than relying on others to pay for their care if they get sick. Therefore it's purpose, is, as you observe, to assure that people do not wait until they are sick to sign up for insurance. That would make effective, let alone affordable, insurance impossible. Experience tells us that that

no alternative mechanism is likely to be nearly as effective as the mandate in achieving participation and affordable coverage.

9. The Affordable Care Act/"Obamacare" took more than $700 billion to spend on new government programs not for seniors. One of the big pay-fors the bill was across-the board annual reductions in the growth rates of Medicare payments for hospitals. Under the law, these cuts are scheduled to continue to be reduced each year, permanently. As a result, the Actuary of the Medicare program has said that if these cuts continue as outlined in the law, either (a) up to 15 percent of hospitals could close and many hospitals would stop taking Medicare patients, or (b) Congress reverses the cuts, increasing the rate of Medicare spending and accelerating the insolvency of the program. In your view, would it better to scrap these reductions and replace them with other policies – and if so, why?

   Answer: As I noted above, health care costs are growing at historically low rates. In the last few years, hospital prices have been stable and hospital use appears to be declining. As a result, CBO has continually reduced its projections of future Medicare spending. The ACA's constraints on hospital payment growth are one of many mechanisms now encouraging hospitals to reduce their actual spending and improve the efficiency with which they deliver care. Alongside broader efforts to reform health care delivery systems—encouraged by the ACA—I believe we are on the right course.

10. During your testimony before the committee, you said "Medicare should not be used as a piggybank" to reduce the debt or pay for other programs. Yet, according to the Congressional Budget Office and the Office of the Actuary at CMS, this is precisely what happened in with Patient Protection and Affordable Care Act/"Obamacare." Under the PPACA, $700 billion was taken from Medicare to be spent on new government programs not for seniors. Would you like to clarify your position?

    Answer: I'm happy to clarify. Arbitrary caps on per capita Medicare spending and a shift from a defined benefit to a defined contribution ("premium support"), as included in several recent Republican budgets, reduce Medicare spending to achieve budgetary targets without specific payment or policy changes—relying on a hope that markets and competition will lower actual beneficiary costs. CBO continually challenges that assumption, arguing that private plans are less able than Medicare to control costs and that fixed voucher payments will shift costs to Medicare beneficiaries, rather than actually reduce costs. That's using Medicare as a piggy-bank for deficit reduction. By contrast, the ACA's $700 billion dollars in spending reductions reflected specific policy changes to reduce overpayments to hospitals and other providers as well as to Medicare Advantage plans. These specific policy changes have, as noted above, contributed to reductions in cost growth in recent years. It's also interesting to note that Republican budgets have retained these measures, and their savings, and propose to cut spending even

further in order to achieve budgetary goals.

11. To be financially eligible for Medicaid coverage for long-term care, including nursing home care, individuals are supposed to have $2,000 or less in countable resources or $3,000 for a married couple. However, a recent GAO report found that nearly 20 percent of the married applicants whose applications they reviewed contained a claim of spousal refusal, whereby an institutionalized spouse transfers all of his or her resources to their community spouse and the community spouse refuses to make the resources available for the institutionalized spouse's care. Using this mechanism, *GAO found community spouses who were able to keep over a $1 million in resources, while Medicaid paid for their institutionalized spouse's nursing home care.* Do you think it is appropriate for millionaires to be receiving Medicaid benefits?

    Answer: Claims that the "rich" are benefiting from Medicaid nursing home and other long-term care coverage are continually challenged by evidence on the limited resources of population that relies on Medicaid—not only when they receive benefits but much earlier in their lives. I urge you to explore my Urban Institute colleague Richard Johnson's extensive documentation of that fact. Further, nursing home use has declined in recent years, in part because people have better access to alternatives, whether in assisted living facilities or at home. The better-off are by far better able to take advantage of those opportunities and demonstrate their reluctance to rely on Medicaid in their patterns of care.

    I would not dispute evidence from specific examples. But the body of evidence tells us that Medicaid recipients of long-term care and other benefits are overwhelmingly people with modest resources.

12. Currently, under the Medicare program, hospitals are reimbursed for the deductibles and co-pays left unpaid by Medicare beneficiaries. This is known as "bad debt." This policy has no parallel in the private sector—or in any other federal program. The president's Fiscal Commission recommended terminating this special subsidy. The president's FY 2015 budget <u>recommended</u> phasing this out as well, estimating it would save taxpayers $30 billion over a decade. Can you talk about the reasons for scrapping this policy?

    Answer: It seems appropriate to consider reimbursement for bad debt as part of overall Medicare hospital payment policy and to assess its relevance or value in the context of other measures.

13. Medicaid was created to provide assistance to individuals whose income and resources are insufficient to meet the costs of necessary medical services. A recent GAO report identified a number of loopholes in Medicaid financial eligibility policies that allow individuals to artificially impoverish themselves in order to qualify for Medicaid coverage of long-term care. Such loopholes include converting countable resources into personal service contracts to pay adult children

or other relatives to provider services such as grocery shopping or transportation or annuities that provide potentially large income streams for community spouses that are not counted towards Medicaid eligibility. Should such loopholes in Medicaid policy that allow individuals of significant wealth to obtain Medicaid benefits be addressed to ensure that limited state and federal resources reach those in most need?

Answer: As I explained above (question 11), the evidence tells us that recipients of Medicaid benefits are overwhelming low and modest income people whose resources prior to needing care were already inadequate to pay for the services they now require. Families struggle to support loved ones needing care; and with or without loopholes current public support is inadequate. What's needed in long-term care is not a "tightening" of loopholes; it's a financing policy that actually insures people against the risk of long-term care needs, whatever their income. I'm happy to provide you more information on long-term care financing issues and options.

14. Do you believe that the Patient Protection and Affordable Care Act/"Obamacare" as it has been enacted and implemented, will:
    a. Reduce or increase the federal deficit over the coming decade?
    b. Reduce or increase state Medicaid spending over the coming decade?
    c. Contribute to reducing or increasing the average cost of a commercial market health insurance plan (not considering the exchange premium or cost-sharing subsidies)?

    Answer: I am comfortable with CBO analysis on the ACA's impact on the deficit. The fact that many states have not taken advantage of the Medicaid expansion is slowing spending growth; that has a positive impact on federal spending, but a negative impact on the people the ACA aims to protect. More positively, CBO has several times re-estimated and lowered its health care spending projections, reflecting a dramatic slowdown in health care spending growth to which the ACA has contributed and which bodes well for the nation's fiscal future.

    Despite the fact that the federal government initially pays the costs of the Medicaid expansion in full and continues thereafter to pay for most of it, expanded coverage will lead to expanded state Medicaid spending as more people are covered by the program. However, analysis by my Urban Institute colleagues and others demonstrates that that spending is offset by savings in other state programs and enhanced revenues to the state—thereby, on net, making a positive contribution to states' fiscal status.

    Evidence indicates that the average cost of commercial health plans in the nongroup market has been lower than expected, as plans compete for the newly eligible population under the ACA. Although low premiums raise some concerns about adequacy of provider networks and high levels of cost-

sharing—both of which can impede patients access to care, cost experience under the ACA has been positive.